

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
: MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04616

Reg. Dist. No.

4624

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Grantsville		b. COUNTY Garrett	
c. LENGTH OF STAY IN 1b 38 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Grantsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print)	First HAROLD	Middle DECITOR	Last BAUM	4. DATE OF DEATH Month April	Day 24	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 18, 1897	9. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY own farm	11. BIRTHPLACE (State or foreign country) Frostburg, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John H. Baum	14. MOTHER'S MAIDEN NAME Inna Youngerman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 974X	16. SOCIAL SECURITY NO. 220-16-6172	17. INFORMANT Mrs. Margaret Baum, Grantsville, Md.	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Instant
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broken Neck By Hanging		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X		
DUE TO (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 4-24-58
EXAMINER'S NAME (Type) James H. Feaster, Jr.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/26/58	22c. NAME OF CEMETERY OR CREMATORIAL Grantsville	22d. LOCATION (City, town, or county) Grantsville Garrett Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don Newman</i>	ADDRESS Grantsville, Md.	24a. REC'D BY REGISTRAR APR 30 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Leach</i>

BUREAU A. S.

APR 30 1963

REGGIEV EDITION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film C228 5-5-58 et
CERTIFICATE OF DEATH

04617

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT		1625 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETT NURSING HOME				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAURA		First ESTELLA	Middle CARSKADON	Lost 4. DATE OF DEATH APRIL	Month 24	Day 1958	Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. - 30 - 1887	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ALBRIGHTSVILLE PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES CHRISTMAN		14. MOTHER'S MAIDEN NAME SUSANA ECKARD		Address GRELLIN. MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT FLOYD CARSKADON		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
						INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1/14 , 19 55 , to 4/24 , 19 58 , that I last saw the deceased alive on 4/21 , 19 58 , and that death occurred at 200ft M, from the causes and on the date stated above. ACTUAL SIGNATURE A. E. Mance		ADDRESS (Street, city or town, state) Oakland, MD.		DATE SIGNED 24 Apr 58			
PHYSICIAN'S NAME (Type) A. E. Mance, M.D.		M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL-26-1958	
22c. NAME OF CEMETERY OR CREMATORIAL TERRA ALTA CEMETERY		22d. LOCATION (City, town, or county) W. VA.					
23. FUNERAL DIRECTOR'S SIGNATURE Bellona Funeral Home		ADDRESS Oakland, MD.		24a. REG'D BY REGISTRAR APR 30 1958		24b. REGISTRAR'S SIGNATURE W. L. Deenach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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BUREAU A.

APR 30 1959

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 8,9 Film G229 5-19-58 et

04618

CERTIFICATE OF DEATH

4626

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Garrett		MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Oakland		3 mo		TOWN Cumberland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cuppett Nursing Home		STREET ADDRESS (If rural give location) 223 Spruce St.	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
Balford Thomas Grapes			April 30 19 58		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 1905	9. AGE last birthday 54 53 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY Textile	11. BIRTHPLACE (State or foreign country) Medley. West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph T. Grapes			14. MOTHER'S MAIDEN NAME Lydia Self		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217-10-7296		17. INFORMANT & ADDRESS Mrs Ruth Boyce, Keyser W. Va	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 581.0 IMMEDIATE CAUSE (A) Cirrhosis of liver					
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Oakland (State) W. Va	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 6, 1958 to Apr. 30, 1958 , that I last saw the deceased alive on Apr. 29, 1958 , and that death occurred at 5:50 P.M. from the causes and on the date stated above. SIGNATURE Luther F. Jones M.D. ADDRESS (Street, city, town, state) Oakland, W. Va DATE SIGNED May 2, 1958					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 3, 1958		NAME OF CEMETERY OR CREMATORIAL Meadow Point LOCATION (City, town, or county) Keyser, West Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Dr. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George K. Chambers Keyser W. Va	
DATE MAY 6 '58					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04619

4627 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Co., Md.		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELIZABETH		First	Middle	Last	4. DATE OF DEATH April 5 1958	Month	Day	Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1874	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Tice		14. MOTHER'S MAIDEN NAME Sara Beachy				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Samuel Hershberger, Grantsville, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		
						INTERVAL BETWEEN ONSET AND DEATH days		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 1958, to <u>March</u> , 1958, that I last saw the deceased alive on <u>March 19</u> , 1958, and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Ruth Peachey M.D.						ADDRESS (Street, city or town, state) Grantsville Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/58		22c. NAME OF CEMETERY OR CREMATORIAL Mountain View		22d. LOCATION (City, town, or county) Salisbury Somerset Co., Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR APR 8 '58		24b. REGISTRAR'S SIGNATURE R. Beachy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1954 CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
APR 8 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04620

Reg. Dist. No.

4628 CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Garrett			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 12 Days		b. COUNTY Grant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Rest Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard		
d. STREET ADDRESS 85 x - 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sarah		First Sarah	Middle Ellen	Lost King	4. DATE OF DEATH April 30. 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7 1889	9. AGE (In years last birthday) 68 yrs.	Month Day Year IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mill Stone, Maryland	
13. FATHER'S NAME John Gay			14. MOTHER'S MAIDEN NAME Sarah Dawson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 232-03-2236		
17. INFORMANT Dorothea Hite, Washington, D.C.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 771A/Influenza			INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Carcinoma of Cervix			6 mos.		
DUE TO (c) 14 person(s)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 14 person(s)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 1951 to 4 - 30. 1958 , that I last saw the deceased alive on 4 - 30. 1958 , and that death occurred at 5 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 21st Oak St. - 1480/50					
DATE SIGNED James H. Feaster, M.D.					
ACTUAL SIGNATURE James H. Feaster, M.D.		PHYSICIAN'S NAME (Type) James H. Feaster, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Bayard Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Bob Duncan			ADDRESS Thomas, W. Va.		
24a. REC'D BY REGISTRAR DATE MAY 5 '58			24b. REGISTRAR'S SIGNATURE Debra		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4629 CERTIFICATE OF DEATH

Reg. Dist. No.

64621

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Grantsville		c. LENGTH OF STAY IN 1b life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Grantsville			

3. NAME OF DECEASED (Type or print)		First MARY	Middle J.	Last MAUST	4. DATE OF DEATH APRIL	Month 1	Day 19	Year 58
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 9, 1872	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY our home	11. BIRTHPLACE (State or foreign country) Meyersdale, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Jonas Maust	14. MOTHER'S MAIDEN NAME Barabara Miller
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. none	17. INFORMANT Elmer Maust, Grantsville, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral thromboses
{ (b) DUE TO Cerebral arteriosclerosis		
{ (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 7-1-57, 1958, to 4-4-58, that I last saw the deceased alive on 3-20, 1958, and that death occurred at 12:55 AM, from the causes and on the date stated above.					
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ACTUAL SIGNATURE Leonard L. Rock MD	ADDRESS (Street, city or town, state) 209 North St Meyersdale Pa.	DATE SIGNED
PHYSICIAN'S NAME (Type) LEONARD L. Rock MD		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/58	22c. NAME OF CEMETERY OR CREMATORIUM Oakdale	22d. LOCATION (City, town, or county) St. Paul, Somerser Co., Pa.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Son J. Newman	ADDRESS Grantsville, Md.	24a. REC'D BY REGISTRAR APR 8 '58	24b. REGISTRAR'S SIGNATURE All. eden	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04655

4630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
GARRETT MARYLAND		MD GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ACCIDENT	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print)		First	Middle
SIMON		EARLE	OPEL
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	APR. 25, 1892	9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) GARRETT Co, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER OPEL		14. MOTHER'S MAIDEN NAME MARY BRENNEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 190-16-3771 17. INFORMANT Mrs Anna Opele, Accident Md. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 minutes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes mellitus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1957</u> , to <u>April 9, 1958</u> , that I last saw the deceased alive on <u>April 8, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Salisbury, Penn 4/1/58	
ACTUAL SIGNATURE <u>G. Paige Strong</u> M.D.		DATE SIGNED 4/1/58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/13/58	
22c. NAME OF CEMETERY OR CREMATORIAL GLADE		22d. LOCATION (City, town, or county) ACCIDENT GARRETT Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don J Newman, Grantsville, Md		24a. REC'D BY REGISTRAR APR 15 '58	
		24b. REGISTRAR'S SIGNATURE Alt. Search	

BUREAU V. S.

APR 15 1958

RECEIVED

1001

STATE OF NEVADA - BUREAU OF ELECTIONS
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04658

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		4631		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Garrett		MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY Garrett	
Rural (Friendsville)		8 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
En Route To Garrett C. Me. Hosp., Oak., Md.		Friendsville, Md.			
3. NAME OF DECEASED (Type or print)		First Lucinda	Middle Sendie	Lost Savage	4. DATE OF DEATH Month 4 Day 18 Year 1958
5. SEX F		6. COLOR OR RACE WIDOWED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7th., 1957	9. AGE (In years at birthday) MOS. 8 1/2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Oakland, Maryland	
13. FATHER'S NAME Foster Savage		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Foster Savage Rt. 1 Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus 491X		INTERVAL BETWEEN ONSET AND DEATH one hour			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Bronchial pneumonia, C. U.			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.		DATE SIGNED 4-18-58			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-58	22c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose Cem.	22d. LOCATION (City, town, or county) Friendsville	
23. FUNERAL DIRECTOR'S SIGNATURE H. Rodale		ADDRESS Markleysburg Pa	24a. REC'D BY REGISTRAR APR 21 '58	24b. REGISTRAR'S SIGNATURE W. E. Egan	
2070294 XV5			DATE		

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
APR 22 1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04657

Reg. Dist. No.

1		4632										2			
1. PLACE OF DEATH a. COUNTY		Garrett			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE Maryland.			b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Friendsville			c. LENGTH OF STAY IN 1b 58 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Friendsville						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		---			d. STREET ADDRESS ---		d. STREET ADDRESS ---					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Orval		Middle Clarence		Last Sliger		4. DATE OF DEATH		Month April	Day 27	Year 1958			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 2, 1899		58 yrs.		Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Laborer		General		Maryland.		U.S.A.									
13. FATHER'S NAME		George W. Sliger		14. MOTHER'S MAIDEN NAME		Mary Elizabeth Uphold									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
no		---		Benjamine Sliger		Friendsville, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarction										1 Hour			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO													
		(b)													
		DUE TO													
		(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>												DATE SIGNED 4-28-58			
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
EXAMINER'S NAME (Type) James H. Feaster, Jr.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/1958		22c. NAME OF CEMETERY OR CREMATORIAL Steele Cemetery		22d. LOCATION (City, town, or county) Friendsville, Md.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '58		24b. REGISTRAR'S SIGNATURE Al. Leighton									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4633

CERTIFICATE OF DEATH

Reg. Dist. No. 04658

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2 Mi. West of Deer Park		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park	
3. NAME OF DECEASED (Type or print) Levi		First Alvin	Middle Smith
4. DATE OF DEATH April 21,	Month April	Day 21	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 9, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Eli Smith		14. MOTHER'S MAIDEN NAME Nancy Hoop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220 03 7463	17. INFORMANT Troy Smith	Address Deer Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hours 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November</u> , 1957, to <u>April 21</u> , 1958, that I last saw the deceased alive on <u>April 21</u> , 1958, and that death occurred at <u>11:45 P.M.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Herbert H. Leighton, M. D. 77 Oak St., Oakland, Md.	
ACTUAL SIGNATURE Herbert H. Leighton	DATE SIGNED April 23, 1958		
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.	Oakland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/1958	22c. NAME OF CEMETERY OR CREMATORIUM Ferndale Church Cemetery	22d. LOCATION (City, town, or county) (State) near Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE APR 22 '58
			24b. REGISTRAR'S SIGNATURE John Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 28 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4634

Item 2 F11mg228 5-12-58 et
 CERTIFICATE OF DEATH

04659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 17 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1617664 (1617664) 01x-2	
3. NAME OF DECEASED (Type or print) First Frank		d. STREET ADDRESS Frostburg, Rt. # 2, Box 83	
4. DATE OF DEATH April		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-84	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroader		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Truly		14. MOTHER'S MAIDEN NAME Elizabeth Thompson Margaret Graham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 712-14-1618	
17. INFORMANT Mr. Kenneth Truly (Son)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, w/ prostatic</i> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>901.9</i>	
		(b) <i>Arteric Sclerotic Cardo-Renal disease Xmas</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture Rt. Femur 4-15-58 - Pinched 4-15-58 in Recovery</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3-15-58 to 4-30-58</i>	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-15</i> , 19 <i>58</i> , to <i>4-30</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-29-58</i> , 19 <i>58</i> , and that death occurred at <i>7:05 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		ADDRESS (Street, city or town, state) <i>58 21 st. Oakland, Md.</i> DATE SIGNED <i>4-30-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-1958	
22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Pk.		22d. LOCATION (City, town, or county) Frostburg (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hafer Funeral Home</i>		24a. REC'D BY REGISTRAR DATE MAY 5 '58	
24b. REGISTRAR'S SIGNATURE <i>Albert Schuch</i>			

CERTIFICATE OF DEATH

OAHU

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4635

CERTIFICATE OF DEATH

Reg. Dist. No.

04660

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia		b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 18 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reeces Mill		d. STREET ADDRESS 85x		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clellie		First Victoria Middle Umstot		4. DATE OF DEATH April 5, 1958		Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1884	9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maysville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Haslacker		14. MOTHER'S MAIDEN NAME Elizabeth Hesse		Address Mrs. Homer Fennell, Westminst, Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Homer Fennell		INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Infected Deoubility & Septicemia Arteriosclerotic Vascular Disease		3 months 10-15 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Dementia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) February 27, 1957 to April 1958						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 77 Oak Street, Oakland, Md.		20f. (City or town) Reeces Mill		(County) W. Va. (State) 1958
21. I certify that I attended the deceased from February 27, 1957 to April 1958 that I last saw the deceased alive on March 25, 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md.		DATE SIGNED APR 11 '58
ACTUAL SIGNATURE Herbert G. Leighton								
PHYSICIAN'S NAME (Type) Herbert Leighton, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Mineral Baptist		22d. LOCATION (City, town, or county) Reeces Mill W. Va.		(State) W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Kogers Funeral Home Inc.		ADDRESS Keyser W. Va.		24a. REC'D BY REGISTRAR APR 11 '58		24b. REGISTRAR'S SIGNATURE Aut. by		

BURIA V. S.

APR 11 1968

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